KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Emergency Services	**Policy #**	3.31-P
Policy Owner	Utilization Management	**Original Effective Date**	04/2005
Revision Effective Date	10/2024	**Approval Date**	12/12/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To Define the circumstances under which emergency services are covered by Kern Health Systems (KHS).

II. POLICY

Emergency services may be provided by any qualified emergency provider. Emergency services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

A. California Health and Safety Code § 1262.8; 1317; 1317.1; and 1371.4
B. California Code of Regulations Title 28 §1300.67(g)
C. California Code of Regulations Title 22 §§53216; and 53855
D. 2004 Department of Health Care Services (DHCS) Contract Exhibit A-Attachment 5(2) and (3); Exhibit A – Attachment 6 (5) and (9).
E. Exhibit A – Attachment 9 (6); and Exhibit E - Attachment 1, (31).
F. Department of Health Care Services (DHCS) Letter: Payment for Emergency Services to Non-Contracted Providers (October 1, 2001)
G. DHCS APL: Authorizations for Post-Stabilization Care Services (May 3, 2023).
H. 42 CFR 438.114
I. DHCS APL 19-008

III. DEFINITIONS

Emergency Medical Condition	An emergency medical condition is a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably: A. Place the enrollee's health in serious jeopardy, B. Seriously impair the enrollee's bodily functions, C. Cause serious dysfunction of any bodily organ or part D. Death. (Cal. Health & Saf. Code § 1317.) E. Active labor" means a labor at a time at which either of the following would occur: 1. There is inadequate time to effect safe transfer to another hospital prior to delivery. 2. A transfer may pose a threat to the health and safety of the patient or the unborn child.
Psychiatric Emergency Medical Condition	"Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: A. An immediate danger to himself or herself or to others. B. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. KHS will be financially responsible for medical emergency care and medical clearance for psychiatric emergencies.
Urgent Medical Condition	Section 1300.67(g)(2) defines "urgently needed services" as "those services necessary to prevent serious deterioration of the health of an enrollee, resulting from unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. Urgent services include, "maternity services necessary to prevent the serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area."

Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility. This includes an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
Post Stabilization Services	Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member's condition.
Stabilized	A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.
Payment for Post Stabilization Services	A. Post-Stabilization Care Services are covered by and paid for in accordance with 42 CFR section 422.113(c). B. Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are authorized by Contractor, Subcontractor, Downstream Subcontractor, or Network Provider. C. In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved. D. Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider

	with privileges at the treating hospital assumes responsibility for the Member's care, a Network Provider assumes responsibility for the Member's care through transfer, Contractor's representative and the treating Physician reach an agreement concerning the Member's care; or the Member is discharged.

IV. PROCEDURES

A. Access

1. Emergency services and care are available and accessible to members on a 24-hour a day, seven days a week basis within the KHS service area. KHS members have access to all emergency service facilities regardless of whether or not the Provider that furnishes the services is a Network Provider, Subcontractor, Downstream Subcontractor or Out-of-Network Provider and the Plan is responsible for coverage and payment for those emergent services .in Kern County. All emergency service facilities in Kern County provide care on a 24-hour-a-day, 7-day-a-week basis with one or more Physicians and one Nurse on duty in the facility at all times.[7] KHS does not require prior authorization for post-stabilization services. KHS provides access to KHS utilization management (UM) staff to include a licensed Registered Nurse (RN) and Medical Doctor (MD) to assist with Emergency Department (ED) coordination of care post ED discharge care continuum.

2. KHS does not require prior authorization for emergency services and care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health[6]. Members may receive emergency services and care from any qualified provider.

   Information regarding emergency department protocols includes, but is not limited to the following:

   a. Description of telephone access to triage and advice systems used by KHS including available translation services.

   b. Plan contact person responsible for coordinating services and who can be contacted twenty-four (24) hours a day.

   c. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.

   d. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action.

e. General information regarding member benefits and administrative procedures for notification, checking eligibility, and claims submission.

3. Members needing advice or triage to an emergent care center may contact the KHS 24-Hour Telephone Triage Service at 1-800-391-2000, available to members outside of KHS regular business hours. This may include an event and or circumstance when a member is necessitating additional resources in the event of a psychiatric emergency during non-business hours. See KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service.

   The KHS Chief Medical Officer or their designee who is licensed as a "physician or surgeon"[9], acting on behalf of KHS's Medical Director, is available twenty-four (24) hours per day, seven days per week to assist with access issues, coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, including appropriate referrals to primary care, behavioral health services, and social services, and for general communication with emergency room personnel. The Chief Medical Officer (CMO) or MD designee is supported by UM staff to assist with service referrals, discharge planning and transfers of members.

4. KHS does not require prior notification for members admitted to acute hospital after stabilization in the Emergency Room (ER). Therefore, the post stabilization admission and services provided in an acute hospital is deemed approved up to the next business day of notification, KHS will review the hospital stay as part of its concurrent review process to determine the medical necessity of continual stay at the acute level of care.

5. When a post-stabilization admission is required for a KHS member at a non-contracted facility, KHS will abide by a standard policy to automatically approve the admission from the time of the admission up to the next business day (weekends and holidays included). On the next business day, the KHS concurrent review department will contact the facility and commence with medical necessity concurrent review and discharge planning to ensure medical necessity criteria is being met for further continuous stay at acute hospital level of care and to address the discharge needs of the member to support his/her care continuum.

6. Out-of-Area Services

   Emergent/ Urgent services are covered if they are provided within the United States. In addition, emergency care services requiring hospitalization are covered if they are provided in Canada or Mexico. Emergency services provided in any other country are not covered.

   All non-contracted emergency facilities within California will be notified on an annual basis of KHS contact information; the notice shall also include, as deemed necessary, information regarding payment and authorization process for non-contracting emergency providers and post stabilization care. It will be the responsibility of the Utilization Management Department to approve language used in the notification letter; it will be the responsibility of the Provider Network Management Department to send the annual notification. See KHS Policy and Procedure 4.11-P Emergency Provider Education and Protocols.

The attending emergency physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on contractor. Contractor must reimburse providers for Emergency Services received by a member from Out-of-Network providers. Payments to non-contracting providers the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge.

B. Covered Services

1. Members presenting to an emergency department in or out of network, for treatment should be provided with a medical screening examination (MSE) to determine whether or not an emergency condition exists. KHS will cover all medical screening examinations to determine if an emergency exists.

2. If, after completion of the MSE, an emergency medical condition is found to exist, the emergency department shall treat and stabilize the member up to and including admission to the hospital when necessary to stabilize the emergency and thereafter to provide post-stabilization services to maintain and treat member's condition requiring acute care. Post post-stabilization notifications are required as follows:

    a. If, after the MSE, an emergency medical condition has been determined not to exist or the emergency condition has been stabilized, post stabilization authorization is not required. In the case of an urgent or emergent admission, the hospital is required to notify the KHS Utilization Management Department within 1 business day of the admission.

    b. Upon notification of the admission, the assigned KHS concurrent review nurse will perform the initial review on the next business day following the admission notification in accordance with the UM Department's concurrent review policy and procedure 33.3-P Titled Admission, Discharge, Concurrent Review, and Authorization Notification Process.

    c. If KHS is contacted after the post stabilization care has been rendered and the member is discharged at the time of notification, the KHS concurrent review staff will advise the admitting hospital staff that the care will be subject to retrospective review, and that clinical records must accompany the claim (see Retrospective Utilization Review Policy and Procedure). All care rendered in the Emergency department and up to post stabilization to treat the emergency will not be denied. Continued post-stabilization care will be reviewed based on medical necessity and will be subject to contractual / administrative notification requirements.

    d. The authorization process, KHS does not require prior notification for members admitted to acute hospital after stabilization in the ER. Therefore, the post

stabilization admission to acute hospital is deemed approved. KHS does not require a non-contracted hospital representative or a non-contracted Physician and Surgeon to make calls to KHS phone number prior to providing post stabilization care to KHS members.

e. For non-contracted hospital admissions KHS does not require patient transfers to a contracted acute care hospital. However, on the next business day a KHS concurrent review nurse will contact the non-contracted hospital to conduct continued medical necessity review and initiate discharge planning and care coordination activities to repatriate the member back to the KHS participating provider network to support ongoing post-acute care as needed. This process may involve executing Letter of Agreements (LOAs) as appropriate with non-contracted providers involved in the members care while hospitalized to prevent any disruption in the care continuum necessary to meet the individual needs of the member related to the hospital episode of care that may not be feasible transferring to a contracted provider.

f. If during the post-stabilization medical necessity concurrent review process there is a disagreement between KHS and the Provider regarding medical necessity of continued acute hospital stay, KHS shall assume responsibility for the care of the patient either by having a qualified medical personnel contracted with KHS that is credentialed to provide care at the non-contracted facility personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with KHS agree to accept the transfer of the patient.

g. For KHS contracted hospitals, the facility shall submit notification of admission either through the KHS provider portal or by faxing the face sheet and clinical documentation to (661) 664-5190 by the next business day. KHS is contracted with a network of hospitalists for each KHS contracted facility to admit KHS members requiring stabilization and ongoing post-stabilization care for its members. Based on the directive of the contracted admitting physicians KHS will approve the admission. If there is not a KHS hospitalist available, KHS will honor the hospital's on-call paneled physicians willing to treat the member as a substitute. KHS will reimburse at Medi-Cal Fee-For-Service (FFS) rates or an agreed upon rate that is different between KHS and the provider. If during a continued post-stabilization concurrent review for medical necessity there is a dispute between the KHS Medical Director or MD designee the case will undergo a peer to peer review process and in accordance with H&S Code 1367.0 in the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

When KFHC is contacted by a non-contracted hospital pursuant to Section 1262.8, KFHC shall reimburse the hospital for post-stabilization care as KHS does not require prior authorization for post stabilization services.

The attending emergency physician, or the provider treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

3. Emergency Psychiatric Conditions

   a. Emergency services and care for psychiatric conditions are covered by KHS, including initial history and physical within twenty-four (24) hours after admission to a psychiatric facility. All other psychiatric services except for initial consults occurring while admitted for other medical condition or other outpatient mild to moderate mental health services are carved out of the KHS Medi-Cal line of Business.

   b. KHS covers all professional services, except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets specialty mental health medical necessity criteria.

   c. KHS covers the facility charges resulting from the emergency services and care of a Plan member whose condition meets Mental Health medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.

   d. Members in need of urgent and emergency psychiatric care that are identified by KHS, including person-to-person telephone transfers, will be referred to the county crisis program center which is open 24/7. A toll-free telephone crisis hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available twenty-four (24) hours a day.

   e. Whenever applicable, best efforts are made to ensure a member's existing mental health Provider is notified during an Urgent Care situation, allowing the existing mental health Provider to coordinate care with MHP and/or emergency room.

4. Emergency Transportation

   a. Coverage includes appropriate ambulance services as described in KHS Policy and Procedure 3.50-P Ambulance Transportation Services. If an enrollee is outside of California and needs a service on an emergency or urgent basis, but that

service is not available in the area or state where the enrollee is physically located, the health plan has an obligation to arrange for the enrollee to obtain the service in a timely manner, consistent with California's timely access standards. This may require the health plan to pay for the enrollee to travel, including travel to another state, to access the care as described in KHS Policy and Procedure 5.15-P Member Transportation Assistance.

5. Emergency Pharmaceuticals

    a. Under emergent circumstances, Provider shall administer and/or dispense a sufficient quantity of medication to the member to last until the member can reasonably be expected to have a prescription filled.

    b. All requests for authorizations, and all responses to such requests for authorizations, of post- stabilization medically necessary health care service admission and ongoing concurrent medical necessity reviews and discharge planning activities shall be fully documented in the member's record in the KHS medical management system. All provisions of medically necessary health care services shall be fully documented. After hours calls may be initially documented to the UM On Call After-Hours Call Log and then be entered into the member's record in the medical management system the following business day.

C. Coordination of Care, Monitoring, and Reporting

KHS must provide notification at least annually to all non-participating hospitals within the state of California on KHS contact information for post-stabilization notification as set forth in the Health and Safety Code, Section 1262.8(j).

The non-contracted hospital shall contact KFHC by either:

1. Following the instructions on the patient's health care service plan member card or call the Utilization Management Department's phone number.

    Monday through Friday / Hours: 8 a.m. to 5 p.m., Pacific Standard Time (PST)
    661.664.5083 or Fax to 661.664.5190

    Afterhours: 800.391.2000 and ask for the Administrator on call or,

2. Send a face sheet with the Member's demographic information to the Utilization Management Fax number: 661.664.5190.

3. KHS monitors primary care practitioners for adequate follow-up care for those members who have been screened in the Emergency Room and require non-emergency care through the Quality Improvement (QI) site review process and reporting.

4. KHS uses Referral/Prior Authorization Forms and other documentation received from practitioners/providers to conduct coordination of care, tracking, and case management activities. Providers may contact KHS UM Nurse to discuss a member's care and any coordination of care needs during a hospitalization by calling (661) 664-5083.

D. Mental Health Coordination of Care

1. KHS Registered Nurses are available 24-hours a day, seven (7) days a week which includes non-business hours, at (661) 331-7656, to provide support and coordination of services to providers involved in member's mental health evaluation and care.

E. Reimbursement

1. Claims must be submitted and are processed in accordance with KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement. Provider disputes regarding claims payment must be submitted and are processed in accordance with KHS Policy and Procedure # 6.04-P Practitioner/Provider Disputes Regarding Claims Payment.

2. KHS reimburses all medically necessary emergency claims according to the eligibility of the member at the time of service and the level of care received by the member. At a minimum, reimbursement for an MSE is made to all emergency room practitioners/providers, (professional and facility component and hospital based urgent care facilities).

3. Contracted providers are reimbursed based on a negotiated rate. Non-Contracted providers are reimbursed at Billed charges or Medi-Cal FFS rates, whichever is less. All services are subject to Medi-Cal Correct Coding Editing and Guidelines.

4. For emergency inpatient services, in the absence of a negotiated rate, claims are reimbursed in accordance with the following guidelines: Applicable Diagnostic Related Group (APR-DRG) reimbursement rates for out-of-network emergency, and post-stabilization acute inpatient services provided to MCP beneficiaries by general acute care hospitals.

5. For the purposes of this Subsection 3.3.16(Emergency Services and Post-Stabilization Care Services), the Medi-Cal FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the Medi-Cal FFS payment method known as diagnosis-related groups which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure Basis methodology (W&I Code§14166 et seq.), less any associated direct or indirect medical education payments to the extent applicable.

   Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 shall constitute payment in full and must not be subject to

subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 shall not have any effect on payments made by Contractor pursuant to this Paragraph 5.

F. Provider Requirements

All non-contract and out-of-area Emergency Departments must follow applicable laws and regulations when KHS members present for care.

G. Delegated Oversight

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services (DHCS) guidance, including applicable All Plan Letters (APLs), Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	HSC §1317.Section 1300.67 (g)(2). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.
Regulatory	HSC §1317.1(a). Definition from DHS Contract Exhibit E-Attachment 1(32) is not included because it is less restrictive.
Regulatory	"For the purposes of Section 1371.4 emergency services and care as defined in this paragraph shall not apply to services provided under managed care contracts with the Medi-Cal program to the extent that those services are excluded from coverage under the contract." HSC §1317.1(a)(2)
Regulatory	HSC §1317.1(j)
Regulatory	CCR Title 28 §1300.67(g)(1); DHS Contract A-6 (5) and A-9 (6)
DHCS Contract	DHS Contract A-6 (5)

Regulatory	CCR Title 22 §53855(a); DHS Contract Exhibit A-Attachment 5(2)(F) and (3)(A); DHS Contract A-9 (6)(A)
Other	"physician and surgeon" added per DMHC comment 9/6/06.
DHCS Contract	DHS Contract A-6 (9) and A-9 (6)©
Regulatory	CCR Title 22§51006
Regulatory	HSC 1371.4(c); CCR Title 22 §53855(a)
Other	DMHC comment letter dated 9/6/2006
Regulatory	CCR Title 28 §1300.67(g)(1)
Regulatory	HSC § 1262.8; CCR Title 28 § 1300.71.4(d)
Regulatory	HSC § 1268.2(j).
DHCS Contract	DHS Contract A-9 (6)(B)

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Review	10/2024	Annual Policy Review.	UM
Revised	7/2024	A purpose statement was added to the policy	UM
Revised	2024-06	Director of Compliance updated the policy, as CMO replaced a paragraph (items D and E on page 6)	Compliance
Revised	2024-04	DMHC Audit Corrective Action Plan	-
Revised	7/2023	Update per DHCS APL 23-009, Authorizations for Post Stabilization Care Services released May3, 2023.	-
Revised	2023-03	Updated per DMHC APL 22-027, Timely Access to Out-of-State Services, released November 7, 2022. DMHC Filing No. 20231556.- Approved on 8/16	-
Revised	4/11/2023	Policy received a disposition of File and Use by the DHCS CM	-
Revised	2021-05	Clarification of language to comply with HSC §1300.71.4 by Director of Utilization Management. Policy was filed with DMHC under Filing No. 202112279	-

Revised	2020-07	Policy updated by Director of Utilization Management based on feedback from the DMHC final report of Routine Survey conducted 8/2019	-
Revised	2020-02	Revised by Director of UM per DMHC comments dated 1/14/2020. Added Section 7.0 for language regarding delegated oversight	-
Revised	2014-08	Revised by Director of Health Services to comply with All Plan Letter 13-004. Revised per DMHC comments dated 9/7/06. Added contract language for dispensing medication in emergency cases. Revised per DMHC Comments dated 09/06/06.	-
Revised	2005-10:	Revised per DHS Workplan Comments 6d (9/1/05) and 6h (9/1/05). Revised to reflect the deletion of external policy 3.15 – Urgent Care/Emergent Care 24 Hour Telephone Triage.	-
Revised	2005-08	Revised per DHS Comments (7/12/05).	-
Revised	2005-04	Policy reviewed against DHS Contract 03-76165. No revision needed per Lacey Campbell	-
Created	2004-05	Created as part of routine revision of emergency services policies. Contains elements of the following policies that will be deleted upon the release of 3.23: #3.12 – Prior Authorization for Urgent Care and Non-Emergent ER Services (2000-05); #6.24 – Emergency/Urgent Care Reimbursement Guidelines (2002-02). Formerly #3.23. 2 HSC §1317.Section 1300.67 (g)(2). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.	-

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Physician Advisory Committee (PAC)		
Quality Improvement/Utilization Management (QI/UM)		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	5/22/2023, 2024 OR R.0180	6/19/2023
Department of Health Care Services (DHCS)	5/10/2023, 2024 OR R.0095	5/22/2023
Department of Managed Health Care (DMHC)	DMHC Filing No. 20231556	8/16/2024